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No. 01-199

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., AND
GREATER NEWPORT PHYSICIANS, INC.,
Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

REPLY BRIEF

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REPLY BRIEF

The opposition brief rests on two, erroneous premises:

First, Respondents wrongly assert that the California court did not decide the question presented in the petition – *viz.*, whether state law claims predicated on a wrongful denial of Medicare benefits "aris[e] under" the Medicare Act, 42 U.S.C. § 405(h). Second, Respondents contend that even if the court so held, the holding will not significantly affect the Medicare program. On these sands, Respondents build their case that the petition should be denied.

In fact, the California Supreme Court expressly opined that it was deciding "the issue whether state law claims against a [Medicare contractor], arising out of its refusal to provide services under a Medicare-subsidized health plan, fall within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies." App. 1a. The complaint alleges that George McCall was denied a Medicare benefit and that this denial breached a number of state law and federal duties.[1] Respondents' newly-minted contentions that "[n]either Pacificare nor GNP denied George coverage of a particular service" and that the complaint alleges "bad care and treatment decisions," Opp. 2, 13, are unsupported by any citation to the complaint. The complaint presents, and the lower courts decided, the issue presented by the petition.

The California court's decision has all the injurious consequences set forth in the petition. It finally decides a

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[1] App. 2a ("[a]llegedly, Dr. Shukla, PacifiCare and GNP repeatedly refused to refer Mr. McCall to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from PacifiCare in order to get on the Medicare list for a transplant"); *id.* at 41a ("[t]he gravamen of [the] complaint is that, to save money, [petitioners] repeatedly refused to refer him to a specialist for a lung transplant, or provide other needed care, and ultimately forced him to leave the plan").

federal question in a way that seriously erodes an important federal policy for purposes of 28 U.S.C. § 1257. See *Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 482-85 (1975). It cannot be reconciled with this Court's authority; further, as the court below acknowledged, "disagreement exists among [the lower] state and federal courts" on the question presented here. App. 1a. Equally to the point, unless this Court steps in, the decision will profoundly damage the Medicare program. The channeling requirement in the Medicare Act serves important federal goals by promoting uniformity and prompt determination of claims and limiting consequential damages. We turn to a detailed demonstration of these points.

I. THIS COURT PLAINLY HAS JURISDICTION.

Respondents assert that this Court lacks jurisdiction because the California court's decision is not final under 28 U.S.C. § 1257, as interpreted in *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469 (1975). Respondents are plainly wrong.

The petition falls squarely within *Cohn*'s delineation of state court judgments that are final under section 1257 even though further state court proceedings are pending:

> [T]here are those situations where the federal issue has been finally decided in the state courts with further proceedings pending in which the party seeking review here might prevail on the merits on nonfederal grounds, thus rendering unnecessary review of the federal issue by this Court, and where reversal of the state court on the federal issue would be preclusive of any further litigation on the relevant cause of action rather than merely controlling the nature and character of, or determining the admissibility of evidence in, the state proceedings still to come. [420 U.S. at 482-83.]

These criteria of finality are clearly met. If petitioners are successful in the pending state lawsuit, the federal jurisdictional defense becomes moot. And, this Court's reversal of the decision would require dismissal of the

complaint for lack of state court jurisdiction. Instead, Respondents argue that the decision does not satisfy *Cohn*'s further requirement that "a refusal immediately to review the state-court decision might seriously erode federal policy," 420 U.S. at 483. This decision, however, determines the scope of the channeling requirement, a central component of the Medicare program. Whatever this Court ultimately decides, the California decision may seriously erode federal policy.

In analogous cases, this Court routinely deems state court decisions final. In *Belknap, Inc.* v. *Hale*, 463 U.S. 491 (1983), the Court deemed final a state court judgment rejecting a defense of federal pre-emption, because permitting "the proceedings to go forward in the state court without resolving the pre-emption issue would involve a serious risk of eroding the federal statutory policy of requiring the subject matter of respondents' cause to be heard by the . . . Board, not by the state courts." *Id.* at 497 n.5 (internal quotations omitted; omission in original). Cf. *Constr. Laborers* v. *Curry*, 371 U.S. 542, 550 (1963) (where the proper forum for trying the issue in the state court turns on the resolution of the federal question, the question should be decided by the Supreme Court sooner rather than later); *Southland Corp.* v. *Keating*, 465 U.S. 1, 6-8 (1984) (a state court judgment is final when a party must face further proceedings in the state courts that those courts lack the power to conduct).

The decision of the California Supreme Court is final.

II. THE COURTS ARE IN CONFLICT.

Ignoring the California court's recognition that a conflict exists, Respondents argue that "[w]ithout exception," all courts "f[ind] that state law claims, including those seeking tort remedies based upon failure to provide Medicare covered services, may be asserted against an HMO or other health care provider as they do not arise under the Medicare Act." Opp. 9. This argument is over-inclusive and under-inclusive,

because it relies on cases that do not so hold and excludes cases directly on point.

a. Respondents correctly characterize cases such as *Ardary* v. *Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996), *Plocica* v. *Nylcare of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999), and *Warternberg* v. *Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998), as holding that state court lawsuits based upon a failure to provide Medicare benefits do not arise under the Medicare Act. But they cite two court of appeals decisions that do not remotely stand for that proposition.

In *Talbot* v. *Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997) and *Alcare, Inc.-N.* v. *Baggiano*, 785 F.2d 963 (11th Cir. 1986), the issue presented was "whether a plaintiff who alleges a violation of the nursing care facility resident rights provisions of the Medicare [or Medicaid] Act must exhaust her *state administrative remedies* before bringing a cause of action for those violations pursuant to 42 U.S.C. § 1983." 118 F.3d at 216 (emphasis provided; citations omitted). The *Talbot* court expressly distinguished its decision from *Heckler* v. *Ringer*, 466 U.S. 602 (1984), because it involved "the exhaustion of *state* administrative remedies" and the plaintiff was not claiming a denial of Medicare benefits. 118 F.3d at 219 n.1. Nothing in either decision purports to address the breadth of section 405(h).[2]

b. Respondents' conflict analysis is under-inclusive because she excludes *Bodimetric Health Services, Inc.* v. *Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), *Midland Psychiatric Associates, Inc.* v. *United States*, 145 F.3d 1000 (8th Cir. 1998), and *Affiliated Professional Home Health Care Agency* v. *Shalala*, 164 F.3d 282 (5th Cir. 1999). These

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[2] Respondents take us to task for an alleged "fail[ure] to apprise this Court of the numerous federal cases directly on point with the present case." Opp. 11 (citation omitted). But the petition cites *Ardary*, *Plocica* and *Wartenberg*, and neither *Talbot* nor *Alcare* is on point.

cases, however, all address the meaning of the phrase "arising under" and conclude that where state law claims are "inextricably intertwined" with Medicare benefits claims, the administrative-exhaustion and federal-judicial review requirements apply. Pet. 14-17 (internal quotation marks omitted) (quoting *Bodimetric*, 903 F.2d at 483). Under these holdings, this case would have been dismissed for lack of jurisdiction.

Respondents distinguish these cases because they were brought not by Medicare beneficiaries, but by Medicare providers. Opp. 11. Respondents nowhere explain why this distinction makes any difference. The statutory language does not distinguish among plaintiffs; it simply requires channeling of "any claim arising under" the benefits provisions of the Medicare Act. 42 U.S.C. § 405(h). The meaning of this provision does not vary with the identity of the plaintiff bringing the state court action.

The holding that "[a] party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits" and "by recharacterizing [its] claims under state and federal causes of action," *Bodimetric*, 903 F.2d at 487, conflicts directly with the decision in this case. In addition, petitioners showed that the California decision conflicts with this Court's established interpretations of section 405(g) and (h). Pet. at 19-23. Respondents ignore this alternative basis for review. Reivew is plainly warranted to resolve these conflicts.

III. THE DECISION BELOW IS WRONG.

Respondents ignore the statutory text; this Court's mandate that the phrase "arising under" be interpreted "quite broadly," *Ringer*, 466 U.S. at 615; this Court's interpretations of "arising under" in other contexts, Pet. 24 n.10; and Congress' intent that "the remedies provided by [the Act's] review procedures shall be exclusive," *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 n.11 (1982) (emphasis omitted). Without repeating

the affirmative case made in the petition, we respond to the opposition's arguments that the decision below was correct.

1. Respondents assert that the Medicare Act, as interpreted by HCFA, "plainly states that tort and other state law claims against an HMO are not preempted, even if such claims also involve Medicare coverage determinations." Opp. 12 (citing App. 14a-15a).[3] The Medicare Act contains no such broad anti-preemption provision. In fact, it *pre-empts* all state laws and regulations "relating to" or "pertaining to" specified areas, including "coverage determinations." 42 U.S.C. § 1395w-26(b)(3); 42 CFR § 422.402. This pre-emption provision is entirely consistent with the broad scope of the channeling provisions.

Without addressing the language of the pre-emption provision, Respondents seek *Chevron*[4] deference for the preamble to HCFA's regulations implementing the BBA. It states that a Medicare contractor's "denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process," but may also be the "subject of a tort case under State law *if medical malpractice is alleged*, or of a state contract law claim *if an enrollee alleges that the [contractor] has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare] contract.*" 63 Fed. Reg. 34,967, 35,013 (June 26, 1998) (emphasis supplied).[5]

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[3] In so arguing, Respondents rely on the express pre-emption provision that the BBA added to the Medicare Act, 42 U.S.C. § 1395w-26(b)(3). The Medicare Act had virtually the same pre-emptive effect prior to the BBA's enactment "'based on general constitutional Federal preemption principles.'" App. 38a (citing 63 Fed. Reg. 34,967, 35,012 (1998)).

[4] *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984).

[5] It is doubtful that a *preamble* to a rule would receive *Chevron* deference. *See United States* v. *Mead Corp.*, 121 S. Ct. 2164, 2171 (2001).

These statements are easily harmonized with the Medicare Act's channeling requirement. Medical malpractice and state contract claims that are inextricably intertwined with Medicare benefits determinations must be channeled, while other such claims may be pursued in state court. As the dissent below stated, HCFA "explains that preemption does not extend to all medical malpractice and contract claims, [but] that has always been the case where the claims were not inextricably intertwined with a benefits determination. . . . [T]he claims asserted here do not fall within these long acknowledged categories of exempted claims." App. 39a.

Petitioners agree that the Medicare Act does not require exhaustion of or pre-empt *all* state law claims of medical malpractice or breach of contract simply because a Medicare beneficiary is involved. Plaintiff has not, however, alleged malpractice or breach of contract. Opp. 13. Where, as here, the Medicare beneficiary seeks merely to challenge a Medicare contractor's determination of benefit eligibility, that determination must be challenged through the Medicare Act's administrative processes.[6] Mr. McCall was required to use that process to challenge the eligibility decision here.

2. Respondents next argue that the decision below is correct because it involves an HMO (which receives a fixed monthly amount to administer and provide Medicare benefits) instead of fiscal intermediaries (which receive administrative fees from the government for determining after-the-fact whether a Medicare claim should be paid, but do not provide benefits). Opp. 13-14. Respondents nowhere explain how this difference alters the meaning of section 405(h). For

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[6] As the *amicus* brief of the American Association of Health Plans, the American Benefits Council, and the Health Insurance Association of America ("AAHP Br.") demonstrates, the administrative process is extremely effective when invoked, protecting the interests of beneficiaries and avoiding the costs and delays of litigation. AAHP Br. 10-11.

exhaustion purposes, the Medicare Act does not distinguish between fee-for-service and managed-care Medicare.

Respondents' unstated argument is that HMOs cannot be trusted to provide Medicare benefits because they have a profit motive to deny benefits, while fiscal intermediaries do not. These propositions are questionable; the Government will not contract with either HMOs that routinely deny appropriate benefits or fiscal intermediaries that routinely grant claims that should not be paid. The critical point, however, is that the policy judgment whether HMOs should be permitted to provide Medicare benefits and on what basis, is for Congress; and Congress has determined that claims "arising under" the Medicare Act's benefits provisions should be channeled, including claims against HMOs.

3. Finally, Respondents contend that some of their claims are "'grievances,'" not "'organization determinations,'" and that only the latter are subject to administrative review. Opp. 14. That distinction is not material here. The legal claims based on grievances – the alleged marketing fraud, failure to implement a quality assurance program, and involuntary disenrollment – are themselves based on the allegation Mr. McCall was unlawfully denied a Medicare benefit. As the dissent explained, all of plaintiffs' claims "are predicated on the central theory that PacifiCare, as a Medicare HMO, was required to comply with all Medicare rules and regulations, that reasonable and necessary health services covered by Medicare would not be denied, and that all available Medicare treatment options would be discussed and provided." App. 33a; see also *id.* ("[a]s for the disenrollment claim, plaintiff George McCall allegedly had to disenroll in order to get the lung transplant he sought"). Accordingly, all of the claims arise under the benefits provisions of the Act and must be administratively exhausted.

IV. THE DAMAGE THAT WILL BE CAUSED BY THE DECISION CANNOT BE OVERSTATED.

Respondents save the most specious part of their argument for last when they argue that the decision – which the dissent characterized as "all but assur[ing] that Medicare's administrative review process will cease to function as a meaningful limit on judicial review," App. 39a – will have only a limited impact on Medicare.

First, Respondents claim the decision's effect is limited to California HMOs, a claim which directly contradicts their contention that the decision follows uniform case law. While Respondents were wrong, the California decision does follow *Ardary*, *Plocica*, and *Wartenberg*. Moreover, almost one-quarter of all Medicare beneficiaries enrolled in managed care reside in California. AAHP Br. 5. Thus, the decision affects millions of Medicare beneficiaries. In any event, the differential treatment of Medicare beneficiaries resulting from the conflict on this issue is fundamentally unfair to all beneficiaries and damaging to the program.

Second, Respondents baldly contend that the ruling affects only HMOs. As explained *supra*, nothing in the decision limits its holding to HMOs. It allows a state court claim predicated on a wrongful denial of benefits to be styled as a tort claim seeking consequential damages and avoid the Medicare Act's channeling requirements. It is immaterial whether the defendant is a fiscal intermediary or an HMO.

Third, Respondents suggest, again without explanation, that the decision "is based upon the law prior to the [BBA]" and therefore that "the impact of this case may be limited in time." Opp. 15. The BBA did not, however, amend section 405(g) and (h) and did not alter the channeling requirement. Indeed, as Respondents themselves essentially concede, the BBA did not even significantly alter the Act's pre-emptive effect. See *supra* at 6 n.3. Respondents point to no provision of the BBA that limits the decision to the pre-BBA period.

Finally, Respondents contend that the decision will have no significant impact on the federal funding of Medicare. They observe correctly that the Government pays HMOs a fixed monthly amount to administer and provide Medicare benefits "regardless of the frequency, extent or kind of health services actually provided" to a Medicare beneficiary and conclude that the federal fisc will be unaffected by elimination of the channeling requirement. Opp. 16.

This contention is premised on the earlier, meritless argument that the decision affects only HMOs (in fact, fiscal intermediaries, too, will be subject to litigation and consequential damages). But, assuming Respondents' mistaken premise to be true, their position – that HMOs will continue to provide health services to Medicare beneficiaries for the same monthly payment even if beneficiaries can avoid the administrative-exhaustion and exclusive federal judicial-review provisions of the Medicare Act by styling their attacks as state law tort claims for consequential damages – is utterly frivolous. HMOs will either refuse to enroll Medicare beneficiaries, increasing the Government's costs, AAHP Br. 4-5, or will raise prices to account for the costs of litigating challenges based on benefits determinations and paying or insuring against consequential damages in such suits. *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 511-12 (1988) ("[t]he financial burden of judgments against [government] contractors would ultimately be passed through, substantially if not totally, to the United States itself, since . . . contractors will predictably raise their prices to cover, or to insure against" liability).

The California court's roadmap for easy circumvention of Congress' scheme conflicts with decisions of this and other courts and damages an important federal program.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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